09/06/2007 07:16 FAX 2024429430

HRA

PRINTED: 09/06/2007 FORM APPROVED

DEPARTMENT OF HEALTH	HAND HUMAN SERVICES	1	W. Appm	FORM APPROV OMB NO. 0938-03
CENTERS FOR MEDICARE STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G164	B. WING		08/17/2007
NAME OF PROVIDER OR SUPPLIER			TREET ADDRESS: CITY, STATE, ZIP CODE 617 DAHLIA STREET, NW WASHINGTCIN, DC 20012	· · · · · · · · · · · · · · · · · · ·
		1-10	PROVIDER'S PLAN OF CORR	ECTION (X5)

NCC		_ "	VASHINGTCIN, DC 20012	-r
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS	W 000		
W 104	This recertification survey was conducted from August 15, 2007 through August 17, 2007. The survey was initiated as a fundamental survey, however due to deficient practices the survey process was extended in the Conditions of Client Protection, Active Treatment and Health Care Services. A random sampling of three clients was selected from the residential population of six females with varying degrees of disabilities.  The findings of the survey were derived from observation, interview, and the review of client and administrative records, including the review of unusual incidents. The survey findings determined the facility did not meet the requirements under the Conditions of Client Protection and Health Care Services.  483.410(a)(1) GOVERNING BODY  The governing body must exercise general policy, budget, and operating direction over the facility.	W 104	A protocol has been developed to ensure the day program receives the physicians orders. All staff have been trained on the protocol. (attachment #1)	9/21/07
	This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility's governing body provided general operating direction over the facility as evidence by the following and deficiencies cited throughout this report.			
	The governing body failed to have an effective system to ensure that day program receive physician's orders.			
	Interview with the case manager and the review of nursing correspondence at the day program	<u></u>	TIMES .	(XS) PATE

Any deficiency statement ending with an exterist () denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether princt a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

р.3

09/06/2007 07:16 FAX 2024429430

HRA

**2**006

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES DICARE & MEDICAID SERVICES

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SUR COMPLETI	
AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	G		-
		09G164	B. WING		08/17/	2007
NAME OF P	ROVIDER OR SUPPLIER			EET ADDRESH, CITY, STATE, ZIP CODE 17 DAHLIA STREET, NW		
ИСС	•			ASHINGTON, DC 20012		
(X4) ID PREFIX TAG	TEACH DESIGNENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROMDER'S PLAN OF CORRECTIVE ACTION SHO (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	IULD BE	(X5) COMPLETION DATE
W 104	Continued From parevealed repeated in physician's orders (1/10/07, 5/22/07, 6/supervisory RN on PM revealed the ordiver to the day probeen notified by the medication orders v.  The governing be system to ensure the dental services are  Any Individual who record must make in the client records of the client	ge 1 requests for current 9/19/06, 9/27/06, 11/6/06, 22/07). Interview with the 8/17/07 at approximately 4:30 ders were sent by the bus ogram and that she had not a day program that the were not received.  sody failed to have an effective hat medicaid approval for received timely. [See W356]  NT RECORDS  makes an entry in a client's it legibly, date it, and sign it.  s not met as evidenced by: and record review, the facility f all personnel making entries lated and signed each entry, ients in the sample. (Clients	W 104	W114		40/4/07
	nursing records rev 2/28/07. The note is assessed and deter swelling, inability to	re W3311 Review of the realed a progress note dated revealed that Client #3 was rmined to have right thigh ambulate, and pain on range a was not initial/signed and did of the assessment.		1. Program Nurse will be trained on appropriate documentation to include off on nursing notes. 2. The QMRP will be trained in the adocumentation of progress notes to signing off.	ie signing ippropriate	10/1/07 10/1/07
	2. Review of Client	is #1, #2, and #3 monthly				

09/06/2007 07:16 FAX 2024429430

HRA

**2** 007

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

CENTER	CO LOW MEDIOWICE	a medicine certification	A	ID C CONSTRUCTION	(XS) DATE SU	IRVEY
STATEMENT AND PLAN O	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDI	IPLE CONSTRUCTION	COMPLE	
		09G164	B, WING		08/17	7/2007
NAME OF P	ROVIDER OR SUPPLIER			reet addresi; city, state. ZIP co 517 <b>Dahlia S'ireet, NW</b> <b>Washingtcin, DC 2001</b> 2	DDE	
(X4) ID PREFIX TAG	/EACH DEFICIENCY	TEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PRIMIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	NISHOULD BE	(X5) COMPLETION DATE
W 120	November, and Der the signature of the Interview with the p the monitoring note and signed by the C 483.410(d)(3) SER' OUTSIDE SOURCE. The facility must as meet the needs of a meet the needs of a meet the needs of a facility failed to ensure that needs of one of the (Clients #3).  The findings include the facility failed to consultant provided accordance with reach A dental consult September 13, 200 calculus and a reconsultant provided accordance with reaches. The recommend on that crevealed that the depreauthorization to would call to resche received. Interview on August 16, 2007 scaling had not been signatured.	g notes for October, cember 2006 failed to have person who completed them, rogram manager revealed that is should have been completed DMRP. VICES PROVIDED WITH ES sure that outside services each client.  Is not met as evidenced by: and record review, the facility it outside services met the ee clients in the sample er.  It is ensure the dental services is services timely and incommended treatments.  It is a the dental services is services timely and incommended treatments.  It is a the dental services is services timely and incommended for scaling of heavy immendation for scaling of heavy immendation for scaling of hended services were not lay. The consultant's report entist would submit Medicaid for approval, and edule once the approval was with the group home nurse of at 11:08 AM revealed the en performed.	W 120	W120  An appointment will be schedu to receive scaling and all additineeded.	led for client #3 onal dental work	10/31/07
	dentist and was dis	agnosed with a mobile tooth				

p.5 Ø008

09/06/2007 07:17 FAX 2024429430

HRA

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 09/06/2007 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO. 0938-0391		
STATEMEN'	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(XZ) MULT. A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		09G164	B. WING_		08/1	7/2007	
	PROVIDER OR SUPPLIER		6	REET ADDRESN, CITY, STATE, ZIP 117 DAHLIA SUREET, NW	CODE	,	
NCC			\\	WASHINGTON, DC 20012		,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF PEFICIENCIES  MUST BE PRECEDED BY FULL  SC (DENTIFYING (NFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT DROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE. THE APPROPRIATE	(X5) COMPLETION DATE	
W 120	-		W 120				
W 122	identified problem of consultant's report submit preauthorization would call to rewas received. At it services had not be a stablished by the of monitoring of the stablished by the stablished	tal services to correct the during that visit. The revealed that the dentist would ation to Medicaid for approval, eschedule once the approval he time of the survey the dental een completed.  ence an effective system was dental provider for timely atus of outstanding requests is needed to provide dental [See also W356, 1] ROTECTIONS	W 122				
W 137	Based on interview failed to implement and procedures (Se evidence that all all thoroughly investigate document the no of investigation find the incident (See W The effect of this sy failure of the facility and to ensure their	is not met as evidenced by: and record review, the facility its Incident Reporting policies be W149); failed to provide egations of neglect were ated (See W154); and to failed tification of the administrator lngs within 5 working days of (156).  stemic practice results in the to protect its clients' rights general safety and well being. DTECTION OF CLIENTS	W 137	All Staff and QMRP will be tr		10/24/07	
		sure the rights of all clients.		appropriate clothing for con- providing day program with clothing regularly.		10/24/07	

09/06/2007 07:17 FAX 2024429430

1 HRA

Ø 009

PRINTED: 09/06/2007 FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

OMB NO. 0938-0391

		& MEDICALD SERVICES	(X2) A	AULTII	PLE CONSTRUCTION	(X3) DATE S	
STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	IDENTIFICATION NUMBER:  A BUILDING  COMPLETED		ETED			
		09G164	B. WI	NG		08/1	7/2007
	ROVIDER OR SUPPLIER			6.	REET ADDRESN, CITY, STATE, ZIP CO	DDE	
исс				ь.,	VASHINGTON, DC 20012	ERECTION	(X6)
(X4) ID PREFIX TAG	(EACH DESICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREI TAI	FIX	PR(MIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	1 SHOULD BE	COMPLETION
W 137	Continued From pa	age 4	w	137			- \
	have the right to re personal possessk	tain and use appropriate	!				·
	Based on observation failed to ensure ear appropriate size, for	is not met as evidenced by: tion and interview, the facility ach clients clothing were of the or three of the six clients d # 5) residing in the facility.					
	The finding include	es:					
	wearing a shirt whi group home for he and 5:43 PM the c same shirt. The ne would not stay in p	8:15 AM Client #3 was observed ich was too large as she left the or day program. At 12:20 PM lient was observed wearing the eckline of the shirt was large, place when repositioned, and to the client's upper arm, her bra.					
·	observed leaving to community walk.	2007 at 5:23 PM, Client #1 was the facility with staff for a Further observation revealed a green flowered shirt which a pair of medium blue very	1				
	Client #1's day pro 10:30 AM revealed program without a morning, after beli Interview with the on 8/15/07 at 10:3 incontinent and was schedule.	ne Activities Coordinator at ogram on August 15, 2007 at d she returned to the day change of clothing that ng out for several days. client's day program instructor 39 AM revealed the client was as on a Q 2 hour toileting					
	On the next day, A	August 16, 2007, the group					

09/08/2007 07:17 FAX 2024429430

HRA

Ø 010

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILD	LTIPLE CONSTRUCTION DING	(X3) DATE SL COMPLE	
		09G164	B. WING	3	08/17	7/2007
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 617 DAHLIA STREET, NW WASHINGTON, DC 20012	DE	
(X4) ID PREFIX TAG	FACH DEFICIENC	ATEMENT OF DEFICIENCIES I MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PRIVIDER'S PLAN OF COM (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
W 137	home received a teday program (locat had soiled her clott of clothing. The dano one was available the client. A changine client by the dalinterview with the plant of the client of the plant of the pla	elephone call from Client #1's ed nearby) indicating that she hing and did not have a change by program was informed that lie to bring more clothing for e of clothing was provided to y program.  I rogram manager on August AM indicated that a change of the day programs for the at they have them when they	W 13	W140  The house manager responsible missing receipts left NCC unexp NCC was unable to recover the land staff will be trained on approximation.	ectedly and receipts. QMRP	
•	Based on staff interfacility failed to mai full and complete a funds entrusted to train the sample. The findings include Interview with the program manager officients financial recognitions and sample.	s not met as evidenced by: rview and record review, the ntain a system that ensured a coounting of clients' personal the facility for three of three e. (Clients #1, #2 and #3) e: rogram manager on August M revealed the group home d the receipts of the clients' ubmitted them to the e for review and filing in the ords. Further interview with the even on duty since August 14,		W149		

09/06/2007 07:18 FAX 2024429430

HRA

Ø 011

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES\_

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI	PLE CONSTRUCTION G	(X3) DATE S COMPLE	URVEY ETED
		09G164	B. WING _		08/1	7/2007
NAME OF F	ROVIDER OR SUPPLIER		6	REET ADDRES: 3, CITY, STATE, ZIP 17 DAHLIA STREET, NW VASHINGTON, DC 20012	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PRITYIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TO DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(XS) COMPLETION DATE
W 140	Continued From pa	ge 6	W 140			
	Record review on A 11:52 AM revealed concerning the fina	ugust 16, 2007 beginning at the following information nces of the clients:				
	2007 revealed on Mand #3, each had a their accounts. The	e bank statements for May  1ay 14, 2007 Clients #1, #2,  withdrawal of \$250.00 from  e review of the requests for the  money was to be used for			·	
	clothing and person available financial r were available for the Interview with the p 16, 2007 at 12:36 F	nal items. The review of ecords revealed no receipts the \$250.00 withdrawals. rogram manager on August PM indicated that follow-up was the if the receipts had been				
	b) The review of Confrom September 20 the bank statement \$100.00 less than to Further review of the revealed the discrept the facility in September 2006 bases.	ancial office.  lient #1's bank statements  06 through July 2007 revealed  s reflected a balance of the facility's ledger balances.  e facility's monthly ledgers  pancy was initially discovered  betember 2006. A note on the onk statement indicated "There				
	ledger. We are still bank on this issue.' there was no evide had been conducte	nce in the bank and book waiting to follow-up with the 'At the time of the survey, nce a thorough investigation d to determine the origin of the en the client's bank and ledger				
	16, 2007 at 11:55 at on a summer vacat 2007. The review of	e program manager on August AM revealed the clients went ion in another state during July of the July 2007 bank d withdrawal of \$530.00 on	•		·	

09/06/2007 07:18 FAX 2024429430

HRA

Ø 012

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A BUILDIN	IPLE CONSTRUCTION	(X3) DATE SU COMPLE	
		09G164	B. WING_		08/1	7/2007
NAME OF F	PROVIDER OR SUPPLIER		(	reet addres), city, state, zip code 117 Dahlia S'ireet, NW Washingtoin, DC 20012		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROMDER'S PLAN OF CORRE (EACH: CORRECTIVE ACTION SHORES-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
W 140 W 149	July 23, 2007 for Cl Interview with the p home manager mai were not available f 483.420(d)(1) STAF CLIENTS The facility must de policies and proced	ients #1, #2, and #3. rogram manager revealed the intained the receipts and they for review during the survey. FTREATMENT OF velop and implement written ures that prohibit	W 140	W149  Educate nursing staff on writing principles and staff on writing principles are specifically, distinguishing indicate time of events in the notes of the note which will aid in clarify	now to s vs. the time ing the	9/27/07
-	This STANDARD is Based on interview failed to establish a management policie	s not met as evidenced by: and record review, the facility and/or implement their incident as to ensure the health and three clients (Client #3) ple.		sequence of events. (meeting sche 9/27/07)  Revised the "Emergency Medical T No Nurse on Site" policy	eduled for	
	management policy notification timefram Review of the facility August 17, 2007 rev Client #3 was discoved between 5:30 AM ar [Note: According to client's sleeping on the Interview with the different was discoved by the client was discove	y's investigative report on vealed on February 28, 2007 vered on her bedroom floor and 5:40 AM unable to stand. The investigative report, the the floor was not unusual.] rect care staff revealed that nouse manager (supervisors) relephone immediately after vered unable to stand. There owever, that the direct care sor contacted nursing/medical				

HRA

DEPARTMENT OF HEALTH AND HUMAN SERVICES FOR MEDICARE & MEDICAID SERVICES

UM/U6/2007 U7:18 FAX 2024429430

PRINTED: 09/06/2007

DEPAR'	TMENT OF HEALTH	I AND HUMAN SERVICES						FORM	APPROVED
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				·			. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) A. BU		TPLE CONSTRU	L	_	(X3) DATE S COMPLI	
		09G164	B. Wil	NG_				08/1	7/2007
NAME OF P	ROVIDER OR SUPPLIER			STI	REET ADDRES	II, CITY, STATE, ZIP	CODE		
NCC					517 DAHLIA S' WASHINGTO	REET, NW M, DC 20012			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH	IVIDER'S PLAN OF CORRECTIVE ACT REFERENCED TO T DEFICIENCE	TON SHOT	ULD BE	(X5) COMPLETION DATE
	According to the fact dated March 14, 20 nurse arrived to the medication, she was Client #3's condition staff ( Primary RN a review of the incider revealed that the client pain at 8:00 AM. Re Administration Recording to the received Tylenol 650 February 28, 2007 a nurse, prior to the maccording to the rep (LPN) assessed the after the incident). A hour after the nurse Registered Nurse (Finability to stand, he that the client appear to the that the client appear to the Right prior to t	cility's investigative report 107, when the medication facility to administer clients' is informed at that time of it. Interview with the nursing and Supervisory RN) and intreport dated 2/28/07 ent was assessed to be interview of the Medication ords revealed that Client #3 0 mg by mouth for pain on 17 AM from the medication outsing assessment. From the medication nurse client at 8:00 AM (2 1/2 hours At approximately 9:00 AM (1 is assessment) the facility's RN) was telephoned by the indinformed of the client's inslightly swollen legs, and ared to be in pain.  The investigative the RN (Supervisor and Primary separately to the facility and 10:00 AM. It should be sation nurse (LPN) left the Ns' arrival. The investigative the RN (Supervisor) did not client's indication on ROM, no swelling, pain on ROM, no swelling, pain on ROM, no swelling to d." Also at that time, the lian (PCP) was contacted and to send client to the	W	149					
		he result of any form of							

09/06/2007 07:18 FAX 2024429430

HRA

**2**1014

PRINTED: 09/06/2007 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (XZ) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDINĞ B. WING. 08/17/2007 09G164 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 617 DAHLIA STREET, NW NCC WASHINGTON, DC 20012 PRINTER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES (X4) 1D PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE CROSS-REFERENCED TO THE APPROPRIATE PRĚFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) W 149 W 149 Continued From page 9. abuse or neglect receive examination of the individual by the physician, nurse practitioner, or other medical professional qualified to make a medical assessment of the injury immediately or within one hour. Further review of the facility's policy revealed, "If emergency medical evaluation is necessary, but not 911 - ambulance service" the facility was required to: 1) Administer emergency medical care as indicated, and 2) Notify the staff physician and proceed as ordered. This policy, however falled to clarify personnel and the time frame for which these steps should be implemented. 2. [Cross Reference W192] There was no evidence that the facility had implemented its policy to ensure that all staff were trained on emergency protocols and first aid. W 154 483.420(d)(3) STAFF TREATMENT OF W 154 CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to provide evidence that all allegations of neglect were thoroughly investigated, for one of the three clients (Client #3) included in the sample. The finding includes:

On August 17, 2007 the facility incident management system was reviewed. As part of that review, an internal investigation of Client #3's

09/06/2007 07:19 FAX 2024429430

HRA

**₫015** 

### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	TPLE CONSTRUCTION	(X3) DATE S COMPLE	
		09G164	B. WING		08/1	7/2007
NAME OF P	PROVIDER OR SUPPLIER		1.0	REET ADDRES:; CITY, STATE, ZIP CO 817 DAHLIA STREET, NW WASHINGTON, DC 20012	<del></del>	
(X4) ID PREFIX TAG	/FACH DEFICIENCY	TEMENT OF DEFICIENCIÉS MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PR()VIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO) CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
W 154	fracture hip was rev investigation reveal witness statements statements available 2007 the nursing a witnesses reflected interviewed. The in discrepancies and in	viewed. Although the ed an evidence list to include , there were no witness e for review. On August 17, and direct care staff, who were in the investigation, were	W 154	W154 This incident was not alleged or be abuse. The investigator will ensure tha investigation file folders will conwitness statements.	t future	9/24/07
	often got out of her on the floor. Although of osteoporosis, the or questioned the st transfers from the bounded, that a 2006 of assessment recommassisted with bed transferd that the facility reviewed the investigation who were medically	mended that the client be ansfers. Also it should be ansfers. Also it should be as human right committee gative report and questioned ra special protocol for clients fragile (i.e. clients who have nosteoporosis and unable to		(a) In the future, the investigator that a thorough review of client records will be completed as painvestigation.  The PT/OT will reassess client # if a transfer protocol is needed. training for all staff will be comp	medical int of the i3 to determine if needed	9/24/07
	medication was admaddress the client Ridid not revealed that was given. The medicated however, regiven at 7:00 AM by	e nurses revealed that pain ninistered on 2/28/07 to OM pain. The investigation pain medication (Tylenol) dication administration flected that medication was the LPN. Review of the evealed the client was N at 8:00 AM.		(b) The investigator will add and the record indicating that Tylem administered to the client by the (c) Although the investigator did the issue of a delay (there are not that specify a time line for this), review Committee did discuss the time of the investigation report. The investigator will ensure that information will be included in fire	ol was LPN. I not discuss NCC policies the incident he delay in their rt. this type of	9/24/07
		nurses revealed that the RN at approximately 9:30 AM.				

09/06/2007 07:19 FAX 2024429430

HRA

Ø 016

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

CLIVI	LINO I OIL MEDIOUILE	G MEDIONIO OLIVOIOLO					CIMID MC	. 0300-0031
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,	IULTIPLE LDING	CONSTRUCTION		(X3) DATE ( COMPL	
		Q9G1 <del>6</del> 4	B. WII	۱G	· · · · · · · · · · · · · · · · · · ·	····	08/	17/2007
NAME OF	PROVIDER OR SUPPLIER			617 0	raddres:), city, st Dahlia s'ireet, no Shington, do 20	w		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTIVE ACTION SHO CED TO THE APPL FICIENCY)	OULD BE	DATE
W 154	The investigation reassessed until 11:00 not discuss the 1 1/2 assessment.  c) Interview with the on duty at the time to telephoned the QMF immediately (5:40 A client's condition. To include what client oprovided to staff at to d) Review of the investigation and supervisory staff and the client staff at t	evealed that the client was not DAM. The investigation did 2 hour delay in the nurses' de direct care staff, who were he incident revealed that they RP and the house manager AM) upon discovering the he investigation did not hare instructions, if any, were hat time.  The staff discovered the client and unable to stand by ith the direct care staff ent was discovered between M.  The reflected that the medical of were immediately notified	W 1	54				
W 156	right committee revie		W 18					
	to the administrator of	stigations must be reported reported representative accordance with State law ys of the incident.		Hosp Origi the c	incident in questio pitalization rather t in. In the future, the classification with t rule) to incidents a prdingly.	than Injury of U le investigator t the greater star	Inknown will apply ndard (five	10/1/07

W 156

**DEFICIENCY**)

09/06/2007 07:19 FAX 2024429430

Continued From page 12

HRA

2017 PRINTED: 09/06/2007

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED A. BUILDING B. WING 09G164 08/17/2007 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 617 DAHLIA STREET, NW NCC WASHINGTON, DC 20012 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (X5) COMPLETION DATE (X4) ID PREFIX PREFIX TAG

W 156

	•				}
		This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to notify the administrator of the result of investigations with in 5 days as required, for one of the three clients (Client #3) in the sample.			
		The finding includes:			
	W 159	On August 17, 2007 review of the facility's system for investigations revealed an investigation of an injury of unknow origin discovered on February 28, 2007 at 12:00 AM. The investigation was initiated on Februry 28, 2007, however, it was no completed until March 14, 2007. There was no evidence that the facility's administrator was notified of the results of the investigation within 5 working days. [See W149] 483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL  Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.	W 159		
		This STANDARD is not met as evidenced by: Based on observation, interview and record verification, the facility failed to ensure each client's active treatment program was integrated, coordinated and monitored by the qualified mental retardation professional (QMRP) for three of three clients residing in the facility. (Clients #1, #2, and #3)			
		The findings include:		W159	
		1. The QMRP failed to ensure as soon as the		(1) The QMRP will be trained in the timely notification of ISP/IPP implementation.	10/1/07
FC	RM CMS-256	7(02-99) Previous Versions Obsolete Event ID: DCNU11	Faci	lity ID: 09G164 If continuation she	et Page 13 of 43

р.15

09/06/2007 07:20 FAX 2024429430

HRA

Ø 018

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT AND PLAN (	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		Q9G164	B. WING		08/17/2007	
NAME OF F	ROVIDER OR SUPPLIER		ε	REET ADDRESS, CITY, STATE, ZIP CODE 17 DAHLIA STREET, NW VASHINGTON, DC 20012		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	FROM DER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOWN CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
	program plan (IPP), continuous active to needed Intervention objectives for Client 2. Interview with the Client #1's day program the day program clearance to return the treatment for an eye with the assightly darked At 2:00 PM, the client group home.  Interview with group PM indicated the the they were not aware to the day program of Interview with the sufficient with the sufficient the day program of the day program of the they was not informed the from the day program the RN contacted the medical clearance for Day Program on 8/10 information was cool necessary persons with medical clearance allowed to return to the day program and the medical clearance for Day Program on 8/10 information was cool necessary persons with a medical clearance allowed to return to the contact of the medical clearance allowed to return to the contact of the medical clearance allowed to return to the contact of the medical clearance allowed to return to the contact of the medical clearance allowed to return to the contact of the medical clearance allowed to return to the client of the	each client received a eatment plan consisting of s to achieve identified s #1, #2 and #3. [See W249]  Activities Coordinator at ram on August 15, 2007 at she was being sent home m due to no medical to the day program after infection. At 10:39 AM Client ting in her class room and to ened area around her left eye. In the was observed back at the client seemed ok and that she was not cleared to return on the morning of 8/15/07. It is she was not cleared to return on the morning of 8/15/07, pervisory RN on 8/15/07 at e client had completed her d that the PCP said she could gram after she finished the 7/8/14/07. She stated that she at the client was sent home m. On 8/15/07 at 7:10 PM, is PCP and obtained the or the client to return to the coordinated to ensure all evere informed of the need for the before the client was	W 159	(2) A protocol will be developed to en information regarding consumers returned the day program are communicated by QMRP and/or house manager to the distaff.	arning to y the irect-care	10/1/07
		her self feeding skills with		(3) Cross-reference W159 (#1). Progr nursing will be trained in verbally communicating pre and post hospital weights to the Nutritionist.		10/1/07

09/06/2007 07:20 FAX 2024429430

HRA

Ø019

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		09G164	B. WING		08/	08/17/2007	
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CO 617 DAHLIA STREET, NW WASHINGTON, DC 20012	DE .		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	FROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	COMPLETION DATE	
W 159	Client #3 was obse assistance and en her spoon and eat group home during Although the client	age 14 erved being provided standby couragement by staff to pick up during lunch and also at her dinner on August 15, 2007. If fed herself, she was observed verbal prompts to continue	W 15.	9			
	The review of Clier revealed the IDT a Client #3's skill of f The client had a primeal time, when ta spoon and feed se According to the IS objective was to be review of the programment.	nt #3's ISP dated 5/21/07 pproved a goal to improve eeding herself with spoon. ogram objective that "During able is set [Client] will pickup lif with 80% Independence". SP, the client's progress in this a monitored by the QMRP. The am data and interview with the 17, 2007 at 2:47 PM revealed collected until August 13, 2007.			·		
	dated dated May 2 the client's self fee had been conveyed Additionally, there thad conferred with	annual nutritional assessment 1, 2007 revealed no evidence ding deficit and training need d to the nutritionist was no evidence the QMRP the nutritionist concerning the during her hospitalization.					
,	Developmental Dis	d to coordinate with ability Services (DDS) and the rding Client #3 lack of and day program.	•	(4) The QMRP will be trained to re during monthly visits to the day p ensure they are current.	view the ISP rogram to	10/1/07	
-	observed with her owith the classroom	7 at 10:39 AM Client #1 was classroom instructor. Interview instructor revealed that both had transferred to the day					

09/06/2007 07:20 FAX 2024429430

HRA

**國 020** 

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	ULTIPLE CONSTRUCTION LDING	(X3) DATE S COMPL	SURVEY ETED	
_		09G164	B, WING		08/-	08/17/2007	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 617 DAHLIA STREET, NW WASHINGTON, DC 20012			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFI) TAG		ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
W 159	program approximathe previous day program objective recreation and leisus implemented.  Interview with Client manager and the reprogram on August revealed no current client. Further interview client's last available	ge 15  Itely 15 months earlier when ogram closed. Interview with gram instructor and the review es revealed sensory, and are objectives were being that's day program case cord verification at the day 15, 2007 at 10:39 AM ISP was available for the view with the case manager are revealed the date of the ease manager are sensored.	W 1	59			
	that having access t effective coordinatio at the group home a	to the ISP facilitates more on of the Client's service needs and at the day program.	,				
		the specific objectives dress Client #1's		(5) Cross-reference W227			
	observed to be very clearing the table aft 2007 at 4:58 PM the information which represcribed a Puree, Ensure Plus, 1 can of 7:52 AM the client wroom with an 8 ounce with staff on August the client received Eweight gain. Subsequently of the suppler	of at 8:15 AM, Client #5 was slim as she assisted in er breakfast. On August 15, program manager provided vealed Client #5 was Double Portion Diet with laily. On August 16 2007 at as observed in the living e can of Ensure. Interview 17, 2007 at 4:40 PM revealed insure twice a day to promote quent observation of the ment in the store room as was available. The Ensure id.		(6) NCC will obtain the proper sclient #5 and train staff in the active supplement.	supplement for Iministration of		

09/06/2007 07:21 FAX 2024429430

HRA

M 021

		I AND HUMAN SERVICES			FORM	: 09/06/2007 APPROVED . 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MÜL A. BUILD	TIPLE CONSTRUCTION ING	(EX) DATE S COMPLE	
,		09G164	B. WING		08/1	7/2007
NAME OF	PROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE 617 DAHLLA STREET, NW		
NCC	·			WASHINGTON, DC 20012		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROMIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-I REFERENCED TO THE APP DEFICIENCY)	QULD BE	(XA) COMPLÉTION DATE
W 159	Continued From pa	ge 16	W 15	9		
	7. Client #3's Occu	pational Therapist		(7) Cross-reference W154 (a)		10/15/07
	recommended on A provide assistance her safety. There we QMRP address the	pril 24, 2006 that the client be during bed transfers to ensure as no evidence that the OT recommendation.  nat interviews with direct care				
W 185	likes to sleep on the client independently night to sleep on the staff, they allow her of records did not re on the floor. It also review of an investig the the cilent was obshe was discovered	2007 revealed that the client floor. According to staff, the gets out of bed during the floor. Also, according to to sleep on the floor. Review eveal a protocol for sleeping should be noted, that the gation report revealed after oserved sleeping on the floor, unable to stand as she was a right fractured hip.	W 18	·	,	
	The facility must provide sufficient support staff so that direct care staff are not required to perform support services to the extent that these duties interfere with the exercise of their primary direct client care duties.			The vacant house manager's position normally assist with the morning care of clients. Until that position is hired NCC will provide one additional staff from 6am to 9am to assist with consumer care.		10/31/07
	Based on staff interviped facility failed to provide that direct care staff support services to the interfere with the exection care duties.	not met as evidenced by: iew and record review, the de sufficient support staff so were not required to perform he extent that these duties ercise of their primary direct direct care staff so that to se one of three clients in the				
	sample. (Client #3).					

09/06/2007 07:21 FAX 2024429430

HRA

**2**022

DEPAR	TMENT OF HEALTH	HAND HUMAN SERVICES	,				FORM	: 09/06/2007 APPROVED : 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING				(X3) DATE SURVEY COMPLETED	
		09G164	B. WII	NG			08/1	7/2007
	ROVIDER OR SUPPLIER		,		et addres(; city, s ' <b>daklia street, i</b>		Ę	
NCC	•			WA	SHINGTON, DC			<del>,</del>
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECT CROSS-REFEREN	PLAN OF CORR CTIVE ACTION S ICED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
W 185	Continued From page 17		w	185				
	The finding includes:							
-	and Staff #6) were services to five (5) met the minimal sta duty failed to provid	7 at 7:20 AM two staff (Staff #5 on duty to provide direct care clients. Although the facility affing requirement, the staff on the sufficient active treatment vices as evidenced below:						
	were observed with their necks as they the bib were used a	breakfast Clients # 1 and #4 n a large, long bib tied around ate their meals. The ends of as a placement, as they client's neck to underneath the						
-	slide on the bib as from it using her rig indicated the bib is soiling their clothing 7:35 AM Client #4 bib from her neck a bib remained on the and the crumbs fell was no evidence then appropriate placemeals. Review of the from the bib remained on the crumbs fell was no evidence the propriate placemeals.	It's plate was observed to she attempted to scoop food the hand. Interview with staff used to prevent the client from the was observed to remove the after finishing her meal. The etable underneath the plate to note the client's lap. There are clients were provided with the mat for use during their the client's individual program include an objective to use a						
	groomed clients' ha At 8:09 AM, Clients bathroom, was obs	#4, who was coming from the erved in the dining with her						
		nts halfway down. Interview						

assistance with dressing. While standing in the

09/06/2007 07:21 FAX 2024429430

HRA

**2**023

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

AND PLAN OF CORRECTION

PRINTED: 09/06/2007
FORM APPROVED
OMB NO. 0938-0391

(X2) MULTIPLE CONSTRUCTION
(X3) DATE SURVEY
COMPLETED

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED		
		09G164	B. Wil	B. WING			08/17/2007	
NAME OF F	ROVIDER OR SUPPLIER			6	REET ADDRESS, CITY, STATE, ZIP COI 17 DAHLIA STREET, NW VASHINGTON, DC 20012	)E		
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE		(X5) COMPLETION DATE
W 185	living room, the statup.  At 8:15 AM the facilication to their day properties to their day properties the facility interview with the dictients #5 and #4 wassistance, the client participate in the hat At 8:25 AM Staff #5 living room and Cliefacility, set in a dining room. She was not 8:57 AM, the client to Undetected by staff observed in the sea chair which was upf 8:52 AM Staff #5 was dining room floor. To supervised, walked dining room wearing supervision. At this room area and Staff duty.  At 9:15 AM Staff #6 station to receive his staff noticed the clief At 9:25 AM, after the medication, Staff #6 medication, Staff #6	ity van arrived to transport the ograms. The clients, ready to depart because of been completed. The clients at 8:25 AM. Although rect care staff revealed that were capable of dressing with his were not observed to ir grooming.  was observed vacuuming the ent #3, who remained at the ing room chair in the living engage in any activity. At got up from the chair.  It a large circular wet area was to fithe client's pants. The holstered was also wet. At as observed mopping the he client, who was not directly for 2 minutes on the wet is wet pants and no direct time Staff #6 was in the bed if #5 was preparing to go off called Client #3 to the nurse is medication. At this time, the int's wet pants.	W	185				
W 192	being cleaned during		W 1	192				

09/06/2007 07:22 FAX 2024429430

HRA

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	<del></del>			(X3) DATE SURVEY	
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. 8UII		COMPLE	COMPLETED	
		09G164	g, WIN	8, WING 08/1			
NAME OF P	ROVIDER OR SUPPLIER	· · · · · · · · · · · · · · · · · · ·		61	EET ADDRESH, CITY, STATE, ZIP CODE 17 DAHLIA STREET, NW		
NCC				WASHINGTON, DC 20012		·	
(X4) ID PREFIX TAG	ZEACH DEFICIENCY	TEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX TAG  CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(XLS) COMPLETION DATE	
14/ 402	Continued From pa	one 19	W	92			
W 192	For employees who	work with clients, training and competencies directed					
	Based on staff inter facility failed to effe emergency measur	s not met as evidenced by: rview and record review, the actively train staff to implement res to prevent neglect for six of cility. (Clients #1, #2, #3, #4, #5					
	The findings include	e:					
		The state of the s	}		W192	Í	
	had been trained in	idence that the staff on duty signs and symptons of I as evidenced below:			(1) Staff will be trained on signs and symptoms of injury.	9/24/07	
	August 17, 2007 re Client #3 was disco between 5:30 AM a [Note: According to	ty's investigative report on vealed on February 28, 2007 overed on her bedroom floor and 5:40 AM unable to stand.			All staff will be trained in CPR/First Aid.	10/31/07	
-	Interview with the dithe direct care supertelephone immediated discovered unable evidence, however, their supervisors corpersonnel at that tirevidence that the dinstruction on how their inability to standindicated in their interview.	the floor was not unusual.] irect care staff revealed that ervisors were contacted via fely after the client was to stand. There was no that the direct care staff or intacted nursing/medical me. Also, there was no irect care staff were given to care for the client in lieu of d. The direct care staff terview on August 17, 2007 at assisted the client to the					
	bathroom for morni client was unable to	ng hygiene care. Because the stand, the staff allowed the edge of the tub while she was					

Ø1025

09/06/2007 07:22 FAX 2024429430

HRA

<u>№</u>1029

PRINTED: 09/06/2007 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-<u>0391</u> CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A BUILDING B. WING 08/17/2007 09G164 STREET ADDRES!; CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 617 DAHLIA STREET, NW NCC WASHINGTON, DC 20012 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (X4) ID PREFIX PRÉFIX TAG TAG **DEFICIENCY**) Continued From page 20 W 192 W 192 bathed. Approximately 5 hours later the client was later taken to the emergency and diagnosed with a right hip fracture. (2) Cross-reference W159 #7 2. Review of Client #3's physician orders revealed that the client was diagnosed with osteoporosis and prescribed Cal-carb w-/vit D 600/200 (2 tabs) daily and Actonel 35 mg once weekly its management. On April 24, 2006. Client #3's Occupational Therapist recommended that the client be provide assistance during bed transfers to ensure her safety. There was no evidence that the facility had implement a training program to address the OT's recommendation. a) Interview with direct care staff on August 17. 2007 revealed that Client #3 "likes to sleep on the floor at times". The staff indicated that the client would get out of bed and lie on the floor. The investigative report comfirmed that the client often sleeps on the floor and had done this for many years. The investigation did not examine or questioned the staff as to how the client transfers from the bed to the floor. Also it should be noted that the facility's human right committee reviewed the investigative report and questioned the facility's need for a special protocol for clients who were medically fragile (i.e. clients who have been diagnosed with osteoporosis and unable to express themselves.) b) On February 28, 2007 at 11:00 PM the direct care staff, going off duty, observed Client #3 in her bed. At 12:00 midnight, however, the

overnight direct care staff observed the client lying on the floor in her bedroom asleep. They allowed her to remain on the floor and checked

Ø 026

09/06/2007 07:22 FAX 2024429430

HRA

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(XZ) MULTIPLE CONSTRUCTION  A BUILDING		(X9) DATE SURVEY COMPLETED	
		09G164	B. WIN	G	08/1	7/2007
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 617 DAHLIA STREET, NW WASHINGTON, DC 20012		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFU TAG	PROMIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-I REFERENCED TO THE APPL DEFICIENCY)	DULD BE	(X5) COMPLETION DATE
W 192	on her hourly. The bother her because would get-up and si 5:30 AM and 5:40 A staff, but could not diagnosed with a rig be determined if the independently transfloor.  3. Interview with the 16, 2007 at 3:50 PM have current CPR of training records pro 16, 2007 revealed in two of the six direct.	ge 21 staff stated that "we did not she is easily aroused and tart walking around." Between M, the client was awaken by stand. The client was later pht fractured hip. It could not eclient fell from her bed or ferred from her bed to the program manager on August Indicated each staff did not certification. The review of vided to the surveyor on June to documented evidence that care employees working with and Staff #5 had a current	W 1	92 (3 & 4) All staff will be trained in CPI	R/First Aid.	10/31/07
W 212	16, 2007 at 3:50 PM have current first aid training records prof 16, 2007 revealed in two of the six direct the clients, Staff #2 first aid certification. 483,440(c)(3)(i) IND The comprehensive identify the presenting and where possible.  This STANDARD is Based on observation review, the facility's comprehensive reas	IVIDUAL PROGRAM PLAN functional assessment must ng problems and disabilities	<b>W</b> 2 <sup>-</sup>	12		

U9/06/2007 07:22 FAX 2024429430

HRA

PRINTED: 09/06/2007

DEPART	MENT OF HEALTH	AND HUMAN SERVICES					. 0938-0391
CENTER	S FOR MEDICARE	& MEDICAID SERVICES	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
STATEMENT AND PLAN OI	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (DENTIFICATION NUMBER:	A BUILDING			COMPLETED	
		09G164	B. WING			08/17/2007	
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESII, CITY, STATE, ZIP COI 17 DAHLIA STREET, NW	DE	
NCC			;		Vashington, DC 20012		
(X4) ID PREFIX TAG	(EACH DEEICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	COMPLETION DATE
W 212	Continued From pa sample. (Client#3) The finding include		W	212	W212		
	August 15, 2007 at revealed on Februa hospitalized for sur fracture of unknown clients Annual India May 26, 2007 reverosteoporosis. Accountmany dated Matransferred to an expension and prehabilitation and pr	nusual incident report on approximately 9:30 AM ary 26, 2007 Client #3 was gical repair of a right hip norigin. The review of the ridual Support Plan (ISP) dated aled a diagnosis of ording to the hospital discharge arch 8, 2007, the client was dended care facility for hysical therapy. Client #3 was roup home on April 23, 2007.			Cross-reference W159 (#1). Progwill be trained in verbally common and post hospitalization weights Nutritionist and Physician.	unicating pre	10/1/07
	program and again home, Client #3 was continuous prompts client appeared to was looking around assessment dated conducted for the 1 weighed 93.5 poun pounds). The review revealed the client February 2007 prio pounds in May 200 nutritionist recommand weight chart maints following additional	at 12:10 PM at her day at PM 6:40 PM at the group as observed to require so by staff to feed herself. The become easily distracted and at The annual nutritional May 21, 2007, which was SP, documented that the client ds (healthy weight 79 - 104 aw of nursing weight records weighed 93 pounds in r to her hospitalization and 85 T. During the assessment, the ended that the client's intake litored for changes. The weights were documented:  (b) July 83 pounds; August 80					

Record review revealed the change in the client's

09/06/2007 07:23 FAX 2024429430

HRA

. Ø1028

PRINTED: 09/06/2007

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A, BUILDING B. WING. 08/17/2007 D9G164 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 617 DAHLIA STREET, NW WASHINGTON, DC 20012 NCC (XIS) COMPLETION DATE PROMDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (EAC) CORRECTIVE ACTION SHOULD BE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAĞ DEFICIENCY Continued From page 23 W 212 W 212 weight had not been identified by the nutritionist and that no further nutritional recommendations were made to address the weight loss. 483.440(c)(4) INDIVIDUAL PROGRAM PLAN W 227 W 227 The individual program plan states the specific objectives necessary to meet the client's needs. as identified by the comprehensive assessment required by paragraph (c)(3) of this section. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure the individual program plan stated the specific objectives necessary to meet the client's communication needs for one of three clients in the sample. (Client #1) The finding includes: Interview with the direct care staff on August 17, 2007 as 9:15 AM revealed that Client #1 was able to say a few simple words, "no, get out, go home, eat" and may be able to learn a few other simple words. Direct staff also stated that the client understands "Sit on the toilet". Record review revealed Client #1's annual W227 Speech-Language Pathology (SLP) Assessment was completed for the May 31, 2007 Individual A augmentative alternative communication Support Plan (ISP). The assessment included an device has been purchased for client #1 and 10/15/07 expected outcome for the client to increase staff will be trained on its implementation. expressive communication through the use of an augmentative alternative communication (AAC) device and included two objectives:

a) Objective - [Client] will use an AAC device to make requests for eating, drinking, sleeping, and

09/06/2007 07:23 FAX 2024429430

DEPARTMENT OF HEALTH AND HUMAN SERVICES

HRA

Ø 029

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			/YEL BATE 64	1BV/EV	
STATEMEN AND PLAN C	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A, BUILL	LYIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		09G164	B. WING		08/1	7/2007	
NAME OF F	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE, ZIP 617 DAHLIA STREET, NW	CODE		
. N C C				WASHINGTON, DC 20012	A A B D C O C C C C C C C C C C C C C C C C C	1	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PRIMDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
W 227	using the bathroom assistance. b) Objective - [Clie say hello and good assistance.	with hand over hand  "it] will use an AAC device to  -bye with hand over hand	W 22	27 42 W242			
W 242	The individual prog those clients who is skills essential for a (including, but not le personal hygiene, bathing, dressing, of basic needs), un	ram plan must include, for ack them, training in personal privacy and independence imited to, toilet training, dental hygiene, self-feeding, grooming, and communication fill it has been demonstrated velopmentally incapable of	VV 24	Program team meeting will be determine need for developm implementation of a dressing Furthermore, staff will be trail privacy to consumers while of	ent and   goal.  ned in providing	10/10/07	
	Based on observation review, the facility for individual program.						
,	8/15/07 at 5:10 PM and at 5:46 PM Clie hallway with her slaup on her hips. The pull both the pants time. The client wawas walked past the escorted back into pants and to wash on 8/17/07 revealed	and on 8/16/07 at 8:09 AM ent #4 was observed in the licks and panties pulled halfway eclient continued to attempt to and panties up at the same intercepted by staff as she edining table. She was the bathroom to pull up her her hands. Interview with staff it that the client can dress it assistance and monitoring					

09/06/2007 07:23 FAX 2024429430

HRA

Ø 030

DEPARTMENT OF HEALTH AND HUMAN SERVICE	ES
CENTERS FOR MEDICARE & MEDICAID SERVICE	<u> </u>

OTATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	PLE CONSTRUCTION	(X3) DATE SU COMPLE	
AND PLAN C	of CORRECTION		B. WING_	<del></del>	0014	7/000
_		09G164				7/2007
NAME OF P	ROVIDER OR SUPPLIER		6	reet addres: , city, state, zip cot 17 <b>Dahlia s'ireet, nw</b> <b>Vashington, do 20012</b>	Æ	
(X4) ID PREFIX TAG	/EXCO DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-INSEFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
W 249	As soon as the inte formulated a client's each client must re- treatment program interventions and si- and frequency to si-	GRAM IMPLEMENTATION  rdisciplinary team has sindividual program plan, ceive a continuous active consisting of needed ervices in sufficient number apport the achievement of the lin the individual program	W 249	W249  QMRP will be trained in ISP impleand monitoring to ensure docum goals/objective are completed in with appropriate timelines.	entation of	10/1/07
	Based on observati review, the facility for interdisciplinary tea program plan (IPP) continuous active for needed intervention	s not met as evidenced by: ion, interview and record alled to ensure as soon as the m formulated the individual , each client received a eatment plan consisting of ns to achieve identified of three clients in the sample. #3)				
ļ	The findings include	e: e W252] The facility failed to				
-	ensure continuous  Goal - to improve h Objective - When g shopping, [Client] w from the community independence. The to the store during t completing the obje implemented daily a Saturdays, Further	er money management skills. iven the opportunity to go iill pay for items purchased y store with 60% client was not observed to go the survey. Instructions for ective revealed it should be and documented on record review revealed no tive had been implemented				

- 09/06/2007 07:24 FAX 2024429430

HRA

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	09/06/2007 APPROVED 0938-0391
STATEMEN"	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SU COMPLE	
		09G164_	B. WIN	lG _		08/1	7/2007
NAME OF F	PROVIDER OR SUPPLIER			6.	REET ADDRESS, CITY, STATE, ZIP CODE 17 DAHLIA STREET, NW VASHINGTON, DC 20012		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL . BC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
W 249			W 2	249			
	consistently implem Record review reve	e W252] The facility failed to lent Client #1 ISP objectives. aled an ISP dated May 31, the IPP, the client had the objectives:			-		
	Objective - When g shopping [Client] wi machine to pay of it	noney management skills liven the opportunity to go Il insert money in a vending the purchase of items with . No data was available since					
	consistently implem Record review reve	e W252] The facility failed to ent Client #3 ISP objectives. aled an ISP dated May 31, the IPP, the client goals and the following:					
	clothes to wear with with staff on August she is also able to d assistance with fast	ompted will pick out a set of 80% independence. Interview 17 2007 at 9:17 AM revealed ress herself, but requires eners and to have her clothing by staff. No data was					
W 252	Objective - At appromoney in vending massistance. No data	e money management skills priate [Client] will insert achine to purchase item with a was available since the ISP. GRAM DOCUMENTATION	W 2	252			
	specified in client inc	omplishment of the criteria dividual program plan documented in measurable				•	

09/06/2007 07:24 FAX 2024429430

HRA

Ø 032

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/06/2007 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

STATEMENT AND PLAN (	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		IG	COMPLE	
		09G164	B. WIN	1G _		08/1	7/2007
NAME OF F	PROVIDER OR SUPPLIER			6	reet addres:), city, state, zip co 117 Dahlia Street, NW Vashington, DC 20012	DE	
(X4) ID PREFIX TAG	(FACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PRIVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
W 252	Based on observation review, the facility for the accomplishment documented in measure three clients in the state of the findings included the findings included the facility failed performance of her on August 15, 2000 observed independed dining, and kitchen with staff on August the client loves to with staff was observed direct care staff on at 4:21 PM. On August 1:02 PM the client vanother community another community Record verification of PM revealed the clie walking skills. The objective which staft will go for walk around minutes." Instruction	s not met as evidenced by: ion, interview and record ailed to ensure data relative to it of the program objective was asurable terms for three of sample. (Client #3)  a: if to document Client #3's walking objective.  That 8:10 AM Client #3 was ently ambulating in the living, areas of the facility. Interview if 15, 2007 at 4:15 PM revealed walk.  Teturning from a walk with August 15, 2007 (Wednesday) pust 16, 2007 (Thursday) at was observed returning from walk with a direct care staff on August 17, 2007 at 2:45 ent had a goal to improve her record further documented an ies "When prompted [Client] and her community for 30 ons to staff require daily	W 2	252	W252 All staff will be trained on goals/call consumers in the home. The trained in ISP implementation is corrected in a timely manner. Completed in a timely manner of include a status report on all ISP goals/objective in the monthly provided in t	QMRP will be d monitoring ect and MRP will	10/30/07
	collection only on To review of program of 2:49 PM reveal no e	he objective and data uesday and Thursdays. The data on August 17, 2007 at evidence that either of the two ad not been documented on theet.					

09/06/2007:07:24 FAX 2024429430

HRA

Ø1033

		HAND HUMAN SERVICES			•	FORM	): 09/06/200 /I APPROVE( ). 0938-039
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	IULTIP ILDING	LE CONSTRUCTION	(X3) DATE S COMPL	SURVEY
	·	09G164	B. Wi	۹G		08/	17/2007
NAME OF	PROVIDER OR SUPPLIER			617	ET ADDRES:, CITY, STATE, ZIP CO 7 DAHLIA STREET, NW ASHINGTON, DC 20012	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING (NFORMATION)	ID PREP TAG	ıx	PROMDER'S PLAN OF CO. (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SKOULD BE	(XS) COMPLETION DATE
	2. On August 15, 2 Client #3 was obserprompts from by sta appeared to becom looking around. The dated May 26, 2007 and objectives were a) Goal - to improve spoon. Objective - During n [Client] will pickup s independence. The the client's progress scheduled to be mo review of the progra new QMRP on August b) On August 15 an observed escorting of wash her hands prior snack and dinner. In 17, 2007 at 9:20 AM receiving training to verification revealed improve hygiene skil "When prompted [Cl at least 60% indeper completing the object implemented daily at week. Record verific was implementation Interview with the ne on August 17, 2007	on at 12:10 PM and 6:40 PM red to require continuous aff to feed herself. The client e easily distracted and was review of the client's ISP revealed the following goals recommended by the IDT.  The skill of feeding self with the neal time, when table is set poon and feed self with 80% review of the IPP revealed in this objective was to nitored by the QMRP. The m data and interview with the ust 17, 2007 at 2:47 PM lection was available since	W	252			

prior to August 2007.

09/06/2007 07:25 FAX 2024429430

HRA

**2**034

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIÉR/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE S COMPL	
		09G164	B. WING		08/*	17/2007
NAME OF I	PROVIDER OR SUPPLIER		617	ET ADDRESS, CITY, STATE, ZIA 7 DAHLIA STREET, NW ASHINGTON, DC 20012		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TON SHOULD BE THE APPROPRIATE	(XS) COMPLETION DATE
	c) Staff was observed irect care staff on at 4:21 PM. On Aug 4:02 PM the client vanother community. Interview with direct at 8:45 AM revealed Record verification of Goal - to improve the Objective - "When particular with the record instructions for commit should be implemented by a manager of the 5/26/07 ISF with the program maindicated the client's implemented howeved objective. During the verified that Client #3 treatment to address the IDT.  2. The facility failed Client #1 ISP objection ISP dated May 31	ed returning from a walk with August 15, 2007 (Wednesday) gust 16, 2007 (Thursday) at was observed returning from walk with a direct care staff.  I care staff on August 16, 2007 I Client #3 "loved to walk." revealed the following:  Le client's walking skills. Frompted, [Client] will go for a munity for 30 minutes."  plefing the objective revealed ented daily and documented	W 252			
	a) Goal - To increase Objective - With hand	self help skills d over hand assistance				

09/06/2007 07:25 FAX 2024429430

HRA

**2**1035

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTER	RS <u>FOR M</u> EDICARE	& MEDICAID SERVICES				CIVID INC.	0930-0381
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIET/CLIA IDENTIFICATION NUMBER:	(X2) A A. BU		TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED	
		09G164	B. Wi	NG .		0.8/1	7/2007
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRES(1, CITY, STATE, ZIP CODE		
NCC					617 DAHLIA STREET, NW WASHINGTON, DC 20012		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC	ΊX	PR(MDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
W 252	Continued From pa	ge 30	W		2		
	[Client] will wear he opportunities( data only since the ISP).	r stockings 60% of the available for 2 days in 8/07					
	observed to pull off have staff put them on August 16, 2007 does not like to kee walk around and plater day program or 16, 2007, the client sock and to walk be available for 2 days b) Goal - To improve Objective - After medishes to the kitche (2 times a week).	7 at 7:50 AM., Client #1 was her socks and lift her foot to on again. Interview with staff at 8:10 AM revealed Client #1 up on her socks, and likes to ay. After returning home from a August 15, 2007 and August was observed to pull off her arefoot until staff noticed her back on her feet. Data only in 8/07 since the ISP.  The home management skills all [Client] will take the cup/or sink with 50% independence at 7:00 PM PM on August 15, sobserved to take her cup to					
	available only for 4 d) Goal - To improv Objective - When p walk around her cor was observed return care staff on Augus however failed to do Interview with the pi	that prompts. Data was on days in 8/07 since the ISP.  The her walking skills rompted [Client] will go for a mmunity for 30 minutes. Staff ning from a walk with direct to 15, 2007 at 4:21 PM, ocument on the IPP.  Togram manager on August the staff implemented the IPP			·		
	objectives develope manager acknowled previous QMRP fail	d by the IDT. The program dged however that the ed to develop IPP data n which the staff could					

Marcus

202-722-2346

p.33

09/06/2007 07:25 FAX 2024429430

HRA

**2**036

PRINTED: 09/06/2007 FORM APPROVED

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA EMENT OF DEFICIENCIES

	r of Deficiencies Of Correction	(X1) PROVIDER/SUPPLIER/SLIA IDENTIFICATION NUMBER:	A. BUI		G	COMPLE	TED
		09G164·	B. WI	4G		08/1	7/2007
NAME OF F	ROVIDER OR SUPPLIER	-	•	6	EET ADDRESS, CITY, STATE, ZIP CODE 17 DAHLIA STREET, NW VASHINGTON, DC 20012		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROMDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	COMPLETION DATE
W 252	3. Client #2 prograrevealed the follow  a) Goal - to improve Objective: When proclothes to wear with with staff on Augus she is also able to assistance with fas	im's data was reviewed and ing: e self help skills rompted will pick out a set of the 80% independence. Interview to 17 2007 at 9:17 AM revealed dress herself, but requires teners and to have her clothing by staff. No data was	W	252			
	[Client] will participe around her home of minutes 80% of the 2007 at 4:05 PM, it community with a dayallable for 1 days c) Goal - To improve	e walking skills rbal prompts and supervision, ate in a walking program r in her community for 30 e opportunities. On August 15, ne client went for a walk in the lirect care staff. Data only in 8/07 since the ISP. we money management skills opriate [Client] will insert					
W 318	money in vending n assistance. No dat 483,460 HEALTH 0	nachine to purchase item with a was available since the ISP. CARE SERVICES sure that specific health care	W		W318 Cross-reference W192, W322, and W	331	
	Based on interviews failed to effectively emergency measur W192); and failed to	s not met as evidenced by: a and record review, the facility train staff to implement es to prevent neglect (See to obtain preventive and are to prevent neglect (See		,			

09/06/2007 07:26 FAX 2024429430

HRA

p.34 **@**037

		AND HUMAN SERVICES		•	FORM.	APPROVED 0938-0391
		& MEDICAID SERVICES	<del>-,</del>			
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G	(X3) DATE SU COMPLE	TED
,		09G164	B. WING_		08/1	7/2007
NAME OF P	ROVIDER OR SUPPLIER	,		REET ADDRES:), CITY, STATE, ZIP CODE		
NCC				17 DAHLIA STREET, NW		
			,	VASHINGTON, DC 20012		
(X4) ID PREFIX TAG	FACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PRIVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS- REFERENCED TO THE APPRI DEFICIENCY)	JILD BE	(XS) COMPLETION DATE
W 318	Continued From pa	ge 32	W 318			
	The results of these in the demonstrated services to prevent	e systemic practices resulted I failure to provide health care neglect.				
W 322	483.460(a)(3) PHYS		W 322	W322	ļ	
	The facility must progeneral medical car	pvide or obtain preventive and re.		Revised the "Emergency Medical Trea No Nurse on Site" policy which addre accountabilities; all of which should to "immediately" including notification on nurse. Staff trained on revised policy	esses staff be done of the	9/24/07
·	Based on observation review the facility fa	s not met as evidenced by: on, staff interview, and record ifled to obtain preventive care or one of three clients in the		Review of the importance of timely mappointments and follow up with recommendations with nursing staff. (meeting/training scheduled for 9/27/0		9/27/07
	The findings include	a;			,	
	ensure prompt nurs	e W192] The facilty failed to ing/medical services to injury as evidenced below:				
	reports on August 1 28, 2007 Client #3 v bedroom floor betweenable to stand. [No investigative report, floor was not unusuate staff revealed that it (non-medical person condition. It is uncle	y's incident and investigative 7, 2007 revealed on February vas discovered on her sen 5:30 AM and 5:40 AM ote: According to the the client's sleeping on the al.] Interview with direct care ney called their supervisors and) to report the client's ear as to what instructions rect care staff on how to ent's care.				
ľ	staff made two atter	estigative report, a direct care npts to help the client stand, lient appeared to be weak in				

09/06/2007 07:26 FAX 2024429430

HRA

**2**038

PRINTED: 09/06/2007

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: COMPLETED AND PLAN OF CORRECTION A. BUILDING B. WING 09G164 08/17/2007 NAME OF PROVIDER OR SUPPLIER STREET ADDRES::, CITY, STATE, ZIP CODE 617 DAHLIA STREET, NW NCC WASHINGTON, DC 20012 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX DATE TAG TAG DEFICIENCY W 322 Continued From page 33 W 322 the knees and sat down on the floor. The client was then assisted by two direct care staff to stand and was escorted to the bathroom, where she sat on the side of the tub while she was bathed. There was no evidence that the direct care staff or their supervisors contacted nursing/medical personnel. Further review of the investigative report revealed that the medication nurse was informed of the client's condition when she arrived to the facility to administer morning medications (time unknown). She assessed the client at 8:00 AM (2 1/2 hours after the incident). At approximately 9:00 AM (1 hour after the nurse's assessment) the facility's Registered Nurse (RN) was telephoned by the medication nurse and informed of the client's inability to stand, her swollen legs, and that she appeared to be in pain. Two RNs (supervisor and primary care nurse) arrived separately to the facility between 9:30 AM and 10:00 AM. The investigative report indicated that the RNs did not assess Client #3 or contact the Primary Care Physician (PCP) until 11:00 AM (5 1/2 hours) after the incident. At that time, the PCP instructed the RN to send the client to the ER for further evaluation.

The client was evaluated at the hospital and diagnosed with a right hip fracture.

2. The facility failed to ensure an ENT assessment was provided for Client #3 as recommended.

On August 15, 2007 at 5:43 PM Client #3 was observed to receive Deep Sea Spray, 2 sprays to each nostril. Interview with the nurse revealed the medication was prescribed as a moisturizer

p.36 Ø1039

09/06/2007 07:26 FAX 2024429430

HRA

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT AND PLAN C	of Deficiencies OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3) DATE S COMPLE A BUILDING				
		09G164	B. WIN	IG		08/1	7/2007
NAME OF F	ROVIDER OR SUPPLIER		•	517	ET ADDRESS, CITY, STATE, ZIP CODE 7 DAHLIA STREET, NW ASHINGTON, DC 20012		
(X4) ID PREFIX TAG	ZEACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-I (EFERENCED TO THE API DEFICIENCY)	ICULD BE	COMPLETION DATE
W 322	for dry nasal mucos Record review revel by the pulmonologic diagnosed with pur- and acute sinusitis, recommended. Inter- supervisory RNs or approximately 4:10 assessment was so due to the specialis appointments. The received a timely E- recommended to co 3. The facility failed sinuses was provide recommended.  Record review revelop the pulmonologic diagnosed with pur- and acute sinusitis, client may require at A CT Scan of the second acute of the second review reversinuses was complete the processinuses was complete the processinuses was complete the consultation repanterior nasal septinabsent. The species may be of a surgice be correlated by El- There was no evide	caled Client #3 was evaluated st on October 3, 2006 and was ulent secretions of both nares An ENT evaluation was erview with the primary and August 17, 2007 at PM revealed the ENT cheduled for March 18, 2008, it having no available are was no evidence Client #3 NT assessment as orrelate her sinus condition.	W	322	Sinus CT scan completed Scheduled to see pulmon 9/25/07.		9/25/07

09/06/2007 07:26 FAX 2024429430

HRA

Ø 040

DEPARTMENT OF HEALTH AND HUMAN SERVICES

	42 FOR MEDICAINE	<u> </u>			= ACMOTEU ATION	WAY DATE :	HDVEV
STATEMENT AND PLAN C	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		09G164	B. WIN	G		08/1	7/2007
NAME OF P	ROVIDER OR SUPPLIER				ET ADDRESS, CITY, STATE, ZIP CO Y DAHLIA STREET, NW	DE	
NGC				W	ASHINGTON, DC 20012	<del></del>	
(X4) ID PREFIX TAG	(FACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL. SC IDENTIFYING INFORMATION)	ID PREFI TAG		FRUVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	COMPLETION DATE
W 322	Continued From pa	ge 35	w 3	22			
	4. The facility falled a pelvic sonogram a gynecologist.	I to ensure that Client #3 had as recommended by the			Pelvic sonogram com 8/22/07.	oleted on	8/22/07
	Client #3 had a GYI 2006 for an annual examination was de uncooperative beha however recommen	on August 17, 2007 revealed N appointment on October 17, pelvic examination. The eferred due to the client's evior. The gynecologist eded a pelvic sonogram. At ey, there was no evidence the d been done.			•		
	5. The facility failed mammogram as regynecologist.	to ensure that Client #3 had a commended by the					
	observed to be adm primary Registered nurse revealed the simprove Client #3's scheduled mammod was observed asleed interview with direct called from the host was uncooperative to PM, the client was of incomplete appoints August 17, 2007 reveappointment on Oct pelvic examination. deferred due to the behavior. The gyne recommended a mar	r at 9:00 AM, Client #3 was inistered Ativan 2 mg by the Nurse (RN). Interview with the sedation was prescribed to cooperation during her gram. At 9:45 AM the client ip in the chair. At 12:45 PM, care staff revealed the staff pital to report that Client #3 for the procedure. At 4:02 observed returning from the nent. Record verification on realed Client #3 had a GYN ober 17, 2006 for an annual The examination was client's uncooperative cologist however ammogram. At the time of the devidence the mammogram					

HRA

09/06/2007 07:27 FAX 2024429430

Ø 041

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 09/06/2007 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 09G164 08/17/2007 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS; CITY, STATE, ZIP CODE 617 DAHLIA STREET, NW NCC WASHINGTON, DC 20012 (X4) 1D SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) W 322 Continued From page 36 W 322 had been done. Bone scan attempted 8/16/07, 8/30/07 6. The facility failed to ensure that Client #3 had and 9/19/07. The nurse will speak 9/24/07 a bone scan as recommended by the with the physician to determine feasibility of increasing amount of gynecologist sedation medication. On August 16, 2007 at 9:00 AM, Client #3 was observed to be administered Ativan 2 mg by the primary Registered Nurse (RN). Interview with the ENT appointment scheduled for March 2008 (unable to get earlier nurse revealed the sedation was prescribed to 9/24/07 appointment due to few providers. improve Client #3's cooperation during her Receptionist states that there are only scheduled Dexa Scan, At 12:45 PM, interview a few slots for clients from group with direct care staff revealed the staff called from homes). Nurse made several the hospital to report that Client #3 was attempts - called again on 9/24/07 to see if appointment could be moved to uncooperative for the procedure. Record an earlier date. verification on August 17, 2007 revealed Client #3 had a GYN appointment on October 17, 2006 for an annual pelvic examination. The examination was deferred due to the client's uncooperative behavior. The gynecologist however recommended a bone scan. At the time of the survey, there was no evidence the bone scan had been done. W 331 483\_460(c) NURSING SERVICES W 331 The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility's nursing services failed to ensure that each client received nursing services in accordance with their assessed needs for two of three clients in the sample. (Clients #1 and #3)

FORM CMS-2567(02-99) Previous Versions Obsolete

The findings include:

1. [Cross Reference W322]. Interview with the

Event ID: DCNJ11

Facility ID: 0BG184

If confinuation sheet Page 37 of 43

HRA

09/06/2007 07:27 FAX 2024429430

Ø 042

		HAND HUMAN SERVICES		•	PRINTEI FORM	): 09/06/200 // APPRÖVE
STATE	MENT OF DEFICIENCIES AN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		MULTIPLE CONSTRUCTION ILDING	OMB NO (X3) DATE ( COMPL	), 0936-039 Survey
		09G164	B. WIN	NG	08/-	1 <i>7/</i> 2007
NAME (	OF PROVIDER OR SUPPLIER			STREET ADDRESS; CITY, STATE, ZIP CO 617 DAHLIA STREET, NW WASHINGTON, DC 20012		112001
(X4) I PREFI TAG	X	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	(X5) COMPLETION DATE
W 33	nursing staff and rev and the investigative evidence that Client was promptly notified	riew of both the nursing notes report, failed to provide #3's primary care physician d, after a change in the was identified by the	w a	Revised the "Emergency Medica No Nurse on Site" policy which a accountabilities; all of which sho 'immediately" including notificat physician. Staff trained on revis	addresses staff ould be done ion of the	9/24/07
	2. [Cross Reference facility's investigative 2007, when the med facility to administer informed at that time Interview with the nur Supervisory RN) and dated 2/28/07 revealed assessed to be in pathe Medication Admirthat Client #3 receive for pain on February medication nurse, pricassessment.	W322] According to the report dated March 14, ication nurse arrived to the clients' medication, she was of Client #3's condition. raing staff ( Primary RN and review of the incident reported that the client was in at 8:00 AM. Review of distration Records revealed different from the per to the nursing		Educate nursing staff on writing notes – specifically, distinguishi indicate time of events in the not of the note, which will aid in clari sequence of events.  (meeting/training scheduled for the note)	ng how to es vs. the time fying the	9/27/07
W 356	TREATMENT  The facility must ensure treatment services that needed for relief of particular restoration of teeth, are health.  This STANDARD is not based on interview and	REHENSIVE DENTAL  re comprehensive dental  rt include dental care  in and infections,  rd maintenance of dental  ot met as evidenced by:  d the record review, the  that comprehensive dental	W 35	Client went to the dentist on 6/11/examination and scaling (as previordered). Scaling was not done a (per consult) by the dentist who me recommendation. Still awaiting pre-authorization (single was a contacted dental office on 9 remind them to obtain pre-authorization)	ously t this time nade the nce fall 06).	9/24/07
	services were provided clients in the sample. ( The finding includes:	timely, for one of three				

If continuation sheet Page 39 of 43

HRA

09/06/2007 07:27 FAX 2024429430

Ø 043

PRINTED: 09/06/2007

CENTE	RS FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES				M APPRO\ 0. 0938-0;
	VT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUIL	ULTIPLE CONSTRUCTION LDING	(X3) DATE	
<u> </u>		09G164	B. WIN	IG	_	17/2007
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF		1772007
ИСС				617 DAHLIA STREET, NW WASHINGTON, DC 20012		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PRCVIDER'S PLAN OF (EACH CORRECTIVE ACT	TON SHOULD BE THE APPROPRIATE	COMPLET DATE
W 356	The facility failed to a received timely denti services.  On August 15, 2007	ensure that Client #3 al maintenance and treatment at 4:21 PM. Client #3 was	. W 3:	56	,	
	with staff sitting besid	anned fruit cocktail ont of her mouth. Interview de the client while she ate d not have a problem				,
	clients teeth was reco authorization would be appointment on June diagnosed "Mobile too tooth #3". The deritist appointment would be	revealed scaling of the ommended and that e awaited. During the next 11, 20007, the same dentist oth #11 and gross decay of tindicated that an escheduled to treat the				
1   c   r   t   re	Interview with the primate approximately 4:00 received an appointmenent on 6/11/07, howeverform the scaling the further review June 1 review J	ization had been obtained. hary RN on August 17, 2007 PM revealed the client ent for the scaling of her ever the dentist did not e client's teeth on that date. 1, 2007 consultation report entioning of dental scaling commended by the dentist. TION DRILLS	W 440	W440	,	
qı	he facility must hold a uarterly for each shift	evacuation drills at least of personnel.	•	All staff has been trained in ap timely fire drills.	propriate and	9/24/07
Ba	ased on interview and	ot met as evidenced by: I record review, the facility In drills quarterly on all				

Event ID: DCNJ11

Facility ID: 08G164

DEPARTMENT OF HEALTH AND HUMAN SERVICES

HRA

Ø1044

		H AND HUMAN SERVICES				PRINTE FOE	ED: 09/06/20 RM APPROV	007 ŒD
i i	TERS FOR MEDICARE MENT OF DEFICIENCIES	& MEDICAID SERVICES  (X1) PROVIDER/SUPPLIER/CLIA			,	OMB N	O. 0938-03	191
	AN OF CORRECTION	IDENTIFICATION NUMBER;	A BUI		TIPLE CONSTRUCTION NG		SURVEY PLETED	
		09G164	B. WIN	1G _	· · · · · · · · · · · · · · · · · · ·	0.0	/17/2007	
NAME	OF PROVIDER OR SUPPLIER		1	ST	REET ADDRESS, CITY, STATE, ZIP CODE		111/2001	~
NCC				6	817 DAHLIA STREET, NW WASHINGTON, DC 20012			
(X4) I. PREFI TAG	X (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFO TAG		PRCVIDER'S PLAN OF CORRECTIVE ACTION SHO (EACH CORRECTIVE ACTION SHO CROSS-LEFERENCED TO THE APP DEFICIENCY)		(X5) COMPLETIO DATE	N
W 44	Continued From page The findings include	=	W 4	<u></u>		<del></del>		
	16, 2007 at 11:37 At staff were assigned or 11:00 PM - 7:00 A with the program ma	rogram Manager on August M revealed the direct care to the 3:00 PM - 11:00 PM M shift. Further interview anager indicated usually the a the facility during the hours ation.			·			
•	Review of the fire dri 2006 through July 20 documented during t	ll records from September 107 revealed none were he following periods:						
W 455	through December 20 b) Weekend day shift 2006 through July 20 c) Weekend overnight September 30, 2006	ft. none from September 07 ht shift: None between since and March 4, 2007	W 45	5 v	V455			
	There must be an act prevention, control, ar and communicable dis	d investigation of intection	-	Ь	All staff has been trained in Infection lew hygiene kits, brushes,combs, etc een purchased and all items have be ndividually labeled.	: have	9/24/07	
	Based on observation failed to ensure an act of potential communic	ot met as evidenced by: and interview, the facility ive program for prevention able disease for six of six facility. (Clients #1, #2, #3,						
	The findings include:				,			
	staff was observed can	at 8:00 AM, a direct care rying a basket containing , which also included hair						

HRA

09/06/2007 07:28 FAX 2024429430

图 045

DEF	PARTMENT OF HEALT	HAND HUMAN SERVICES				PRINT	ED: 09/06/2	2007
CEN	ITERS FOR MEDICARE	& MEDICAID SERVICES			•	FOI	RM APPROV	VED
STATE	MENT OF DEFICIENCIES AN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(DC2) N	NULTIPL	LE CONSTRUCTION		10.0938-0 E SURVEY	<u> 391</u>
		DENTIFICATION NUMBER:	A. BU	ILDING	<del></del>		PLETED	
		09G164	B. Wit	NG	1		9 /d <b>9</b> /b o o o o	
NAME	OF PROVIDER OR SUPPLIER			STREE	ET ADDRESS, CITY, STATE, ZIP (		3/17/2007	
NC	;			617	DAHLIA STREET, NW	<i>7</i> 00 <i>E</i>		
(X4)	SIMMARY STA	TEMENT OF DEFICIENCIES	_ ,	WA	SHINGTON, DC 20012			
PREF	DX   (EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PR(MIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE E APPROPRIATE	COMPLETI DATE	DN
W 4	. A management of a court box		W 4	155			<del></del> -	$\dashv$
	brushes and combs	. The staff was observed			•			ı
	grooming the hair of	Clients #1, #3, #4, and #5 in to their boarding the bus for	· ]					ł
	meir day programs.	The staff was not observed					}	- 1
	to wash her hands a	fter grooming each client's			•			i
	staff revealed the br	ation and interview with the ushes and combs had no						Ī
	identification.			-			}	-
	Subsequent observa	tion at 8:50 AM on the same						-
•	<ul> <li>morning and interview</li> </ul>	W With the staff revealed			•			
	Several brushes and	combs, in addition to ored together the basket on		- 1				
	the closet shelf in Client	ent #1's bedroom. The staff.					1	
	indicated that they wa	ere stored in this manner to		-				
	no evidence the facili	orn rummaging. There was ty exercised infection control						-
	procedures during ha	ir grooming.		•	,			- 1
	2 On August 16, 200	7 at 8:57 AM Client #3			•			
	Observed to getting up	of from the upholstered chair.	1					
	A large circular wet ar	Ba was observed in the seat			1			1
	I clients wet pants were	nd also on the chair. The ediscovered by staff and		İ				
•	changed at 9:25 AM	The seat of the chair was		1		÷		-
W 460	483.480(a)(1) FOOD	aned during the survey.	134	_				
	SERVICES	AND INCINION	W 460	٠ اد			1	ı
	Fach client							
	Each client must received well-balanced diet inch	ve a nourishing, Iding modified and		1				1
	specially-prescribed dis	ets.		1			1	i
}					÷.	•	1	
	This STANDARD is no	of met as evidenced by:		W488			1	1
N 488	483.480(d)(4) DINING	AREAS AND SERVICE	W 488	All sta	aff has been trained in infect	ion control.		1
]	The facility must assure	e that each client eats in a		All Sta	aff have been trained on pro- umers opportunities for activ	vidina	9/24/07	1
	manner consistent with	his or her developmental		during	If the meal time process to in	clude family		
				]⇒tyle ¢	dining and serving themselv	es if capable.		1

09/06/2007 07:28 FAX 2024429430

HRA

Ø 046

		AND HUMAN SERVICES  ** MEDICAID SERVICES		i	FORM	D: 09/06/2007 MAPPROVED D: 0938-0391
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI	TIPLE CONSTRUCTION NG	(X3) DATE	
		09G164	B. WING		001	17/2007
NAME OF I	PROVIDER OR SUPPLIER			REET ADDRESI), CITY, STATE, ZIP C 617 DAHLIA STREET, NW WASHINGTC:N, DC 20012		11/2007
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE EAPPROPRIATE	(X5) COMPLETION DATE
W 488	Continued From pag level.	ge 41	W 488		-	
	Based on observation failed to ensure that the facility ate in a madevelopmental level.  The findings include:  1. On August 16, 20 breakfast and again a PM during dinner, Cliobserved with a large necks as they ate the bib were used as a p	•				
a a A u c c	was observed to slide attempted to scoop for nand. Interview with a used to prevent the claim of the province	staff indicated the bib is lient from soiling their themselves. The client was ece of bacon on her plate as long which she was not mouth. Record review on 40 PM revealed Client #1 is				

FORM CMS-2587(02-98) Previous Versions Obsolete

If continuation sheet Page 43 of 43

09/06/2007 07:29 FAX 2024429430

HRA

团 047

		HAND HUMAN SERVICES  & MEDICAID SERVICES				FOR	D: 09/06/2007 M APPRÓVED D. 0938-0391	
	FEMENT OF DEFICIENCIES PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ULTIPL LDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
1		09G164	B. WING					
NAME OF	PROVIDER OR SUPPLIER			617	T ADDRESH, CITY, STATE, ZIP CO DAHLIA S'IREET, NW SHINGTON, DC 20012	08/17/2007 IP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI		PROMDER'S PLAN OF COP (EACH CORRECTIVE ACTION CROSS-LIEFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
W 488	Continued From pa	ge 42	W 4	88		<u> </u>	<del> </del>	
	2. The facility failed provided the opport style dining.  a. The clients were a August 15 and 16, 2 August 16, 2007. Cobserved participating placements a Staff were observed in the kitchen by the brought to the dining the clients. Interview of the client's may be plates with assistance	to ensure clients were unity to participate in family observed during dinner on 007 and during breakfast on lients #2 and #5 were ig in setting the table by and silverware on the table, to be served onto the plates direct care staff, then room table to be eaten by with staff revealed that some able to put food onto their ie. There was no evidence ided an opportunity to				•		

Event ID: DCNJ11

Facility ID: 09G164

STATE FORM

р.3 Ø 048

HRA

U9/U0/2007 07:29 FAX 2024429430

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI		A BUILDING	,		E SURVEY IPLETED
		09G164		B. WING			8/17/2007
NAME OF P	ROVIDER OR SUPPLIER				TATE, ZIP CODE		
NCC			617 DAHLI WASHINGT	ON, DC 20	NVV 0012		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE: MUST BE PRECEDED BY SCIDENTIFYING INFORMA	FULL	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	FLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLET DATE
1 000	INITIAL COMMENT	rs		1 000			
	from August 15, 200 A random sampling selected from a resifemales with menta disabilities. The find based on observation	ensure surveys was on 07 through August 17 of three residents want idential population of 1 retardation and other dings of the survey was ons, interviews and the tinistrative records into the survey was the survey the su	7, 2007. as six er ere ne review				
1 052	3502.10 MEAL SER	VICE / DINING ARE	AS I	052	1		
1	tables, chairs, eating	equip dining areas w g utensils, and dishes e developmental nee	š			·	
\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	The GHMRP failed t was equipped with c developmental need	net as evidenced by: to ensure that the din thairs designed to me ts of Residents #1, #3	ing room et the				
1	The finding includes:	:		1			
v d d	vas observed to get lining chair which wa loor. A large circula	07 at 8:57 AM Resid up from a fabric upho as placed beside the r wet area was obser s pants and also on t	olstered front ved in	(1 ar be	propriate cleaning en trained in infect	cleaned by staff using the solution. All staff have lon control procedures.	10/15/07
	Note: There was no leaned during the su	evidence the uphoist urvey.)	tery was	, ,	e home.	purunaseu in piaceo in	9/30/07
b. P	reakfast and again o M during dinner, Re	07 at 7:20 AM during on August 16, 2007 a sidents # 1 and #4 w e, long bib tied around	it 5:30 vere		•		

HRA

Ø 049 PRINTED: 09/06/2007 FORM APPROVED

STATEME AND PLAN	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU	ER/CLIA IMBER:	A. BUI	ULTIPLE CONSTRUCTION LDING	(X3) DAT	E SURVEY
		09G164	<u></u>	a. Wir	-	ر ا	3/17/2007
NAME OF	PROVIDER OR SUPPLIER				TY, STATE ZIP CCIDE		3/17/2001
NCC	T		617 DAHI WASHING	LIA STRE STON, DO	ET, NW 20012		
(X4) ID PREFIX TAG	LACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY C IDENTIFYING INFORMA	EI II I	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-IKEFERÊNCED TO THE DEFICIENCY	ON SHOULD BE IE AFPROPRIATE	(X5) COMPLETE DATE
1 052	Continued From pag	ge 1		I 052			
	necks as they ate the bib were used as a p from the resident's n on the table. There were residents were provide mat for use during the	eir meals. The ends place mat, as they ex eck to underneath the was no evidence the ded with an appropri	dended ne plates	. 302			
1 090	3504.1 HOUSEKEEF	PING	İ	1 090			
1	The interior and extermaintained in a safe, and sanitary manner accumulations of dirt, odors.  This Statute is not me	clean, orderly, attractand be free of rubbish, and object	ctive,				
1	The facility failed to make evidenced by the control of the report.	ai⊓tained the enviro	nment this				
Т	he findings include:					•	
oi ei be	he surveyor conducted bservations during the national rounds of the national rounds of the national rounds of the national rough the national rough manager.	e survey and during on August 17, 2007 The surveyor was	the		1 .		
1.	A long crack was ob e top step at the front	served across the water of the GHMRP.	ridth of		1090		
(fri ma the	Several holes were ont) basement wall. I anager revealed wate exterior of the facilit or to the survey due to	Interview with the pro or entered the wall fro or approximately one	ogram om week	ì	(1) Front concrete steps will be re	Į.	11/1/07
h Regulation	Administration			<u> </u>			}

Heal

STATE FORM

DCNJ11

09/06/2007 07:29 FAX 2024429430

HRA

**2**050

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIDENTIFICATION N		ER/CLIA IMBER:	A BUILI		(X3) DATE COMP	SURVEY LETED
		09G164	· · · · · · · · · · · · · · · · · · ·	B. WINC		08/	17/2007
NCC	VAME OF PROVIDER OR SUPPLIER			DRESS, CIT LIA STREE STON, DC	Y, STATE. ZIP CCDE ET, NW 20012		
(X4) ID PREFIX TAG	I (EACH DEFICIENCY	TEMENT OF DEFICIENCIE 'MUST BE PRECEDED BY SC IDENTIFYING INFORMA	Maria 1	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT  (EACH CORRECTIVE ACTION SHOU  CROSS-REFERENCED TO THE APPRO  DEFICIENCY)	3401	(X5) COMPLETE DATE
8. st 9. ki 10 Oi to 11	3. On 8/15/07 at 5:1 heard coming from a basement wall . Sev had stopped. The s	4 PM, a beeping noise a red box installed or real minutes later the ame noise was hear hout the day on 8/17, fogram Manager on a revealed the beeping alarm system. Resent to pped the beeping of the return. The prograt efforts to correct title.  Delow the downspoute GHMRP was observed in the floor of the hallwheavily stained tiles dining room floor.  Deabinet underneath the ched from the sides	n the e noise of d /07. August of noise of the noise of the vertice	<ul> <li>(3) Alarm system will be repaired.</li> <li>(4) A splash block will be purchased.</li> <li>(5) The broken window well covers wireplaced.</li> <li>(6) The dining room and hallway floor be replaced.</li> <li>(7) The kitchen sink cabinet will be replaced.</li> <li>(8) The kitchen cabinets will be thorout cleaned.</li> <li>(9) A new kitchen trash can with a lid wirth purchased.</li> <li>(10) The chandelier bulb will be replaced.</li> <li>(11) The rubber floor covering on the sibe replaced.</li> <li>(12) The hallway door will be repaired/a replaced.</li> </ul>	tiles will paired. ghly vill be ed.	11/1/07 10/15/07 10/15/07 11/1/07 11/1/07 9/30/07 9/27/07 11/1/07	

HRA

**2**1051

PRINTED: 09/06/2007 FORM APPROVED

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 09G184 NAME OF PROVIDER OR SUPPLIER 08/17/2007 STREET ADDRESS, CITY, STATE, ZIP CODE 617 DAHLIA STREET, NW NCC WASHINGTON, DC 20012 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (XA) COMPLETE TAG (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY 1 090 Continued From page 3 1090 from the steps leading to the basement and the steps had not been resurfaced to render them easily cleanable. 12. The door of the bathroom located off the hallway would not open completely. Further observation of the door revealed it dragged against the floor near the bathroom storage cabinet 1135 3505.5 FIRE SAFETY I 135 I 135 Each GHMRP shall conduct simulated fire drills in Staff have been trained in the appropriate and order to test the effectiveness of the plan at least timely implementation of fire drills. 9/24/07 four (4) times a year for each shift. This Statute is not met as evidenced by: The finding includes: Based on interview and record review, the GHMRP failed to conduct simulated fire drills at least four (4) times a year for each shift. The findings include: Interview with the Program Manager on August 16, 2007 at 11:37 AM revealed the direct care staff were assigned to the 3:00 PM - 11:00 PM or 11:00 PM - 7:00 AM shift. Further interview with the program manager indicated usually the residents were not in the facility during the hours of day program operation. Review of the fire drill records from September 2006 through July 2007 revealed none were documented during the following periods: a) 3:00 PM - 11:00 PM shift - September through December 2006 b) Weekend day shift: none from September Health Regulation Administration

09/06/2007 07:30 FAX 2024429430

HRA

Ø1052

PRINTED: 09/06/2007 FORM APPROVED

NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUM	VCLIA IBER:			(X3) DATE COMP	SURVEY
_	09G164		B. WING		-	
PROVIDER OR SUPPLIER	<del></del>	STREET AD	DRESS CITY	/ STATE TIP CORE	<u>  08/</u>	17/2007
	•	617 DAHL	JA STREE	T. NW		
(EACH DEFICIENCY	MUST BE PRECEDED BY EL	ULL ION)	ID PREFIX TAG	CROSS-REFERENCED TO T	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
Continued From page	ne 4		I 135		<u></u>	<del> </del>
2006 through July 20 c) Weekend overnic	207 aht shift: None betwee	en 1007				
3508.7 ADMINISTRA	ATIVE SUPPORT		l 189	l 189		
Each GHMRP shall r funds received and	naintain records of res disbursed.	sidents	,	Missing receipts left NCC unex NCC was unable to recover the	spectedly and	9/24/07
Based on interview at GHMRP failed to mail	nd record review, the Intain complete accoun	nting 1#3.		and staff will be trained on app submission.	propriate receipt	
The findings include:		-				
no, 2007 at 17:43 AM manager maintained to Residents' expenditure the administrative official residents financial with the program manager.	revealed the group hat he receipts of the sand submitted then to filling records. Further interespectively records.	ome n to lin				
1.02 AM revealed the	following information	g at				
The review of the ba 107 revealed on May of 2, and #3, each had a 10m their accounts. The 10m their accounts. The 10m their accounts the funds indicated to 10m their accounts for the same 10m their accounts are available for the \$2 10m their accounts the progression of the base 10m their accounts the progression of the base accounts the base accounts the progression of the base accounts the base account the base accounts the base accounts the base accounts the base accounts the base accounts the base accounts the base account the base accounts the base accounts the base accounts the base accounts the base accounts the base accounts the base accounts the base accounts the base accounts the base accounts the base accounts the base accounts the base accounts the base accounts the base accounts the base accounts the base accounts the base account the base accounts the base accounts the base accounts the base accounts the base accounts the base accounts the base account the base accounts the base accounts the base accounts the base accounts the base accounts the base accounts the base accounts the base accounts the base accounts the base accounts the base accounts the base accounts the base accounts the base accounts the base accounts the base accounts the base accounts the base acco	ank statements for Ma 14, 2007 Residents #1 withdrawal of \$250.00 be review of the reque- he money was be use al items. The review of ds revealed no receipt 250.00 withdrawals.	f, o) sts ed of ts				
	SUMMARY STAREACH DEFICIENCY REGULATORY OR LS Continued From page 2006 through July 20 c) Weekend overning since September 30, 3508.7 ADMINISTRATE Each GHMRP shall r' funds received and This Statute is not me Based on interview and GHMRP failed to main of funds disbursed for funds disbursed for funds disbursed for funds disbursed for the findings include: The findings include: The findings include: The review with the program manager maintained to Residents' expenditure administrative officine residents financial with the program manager manager had no ugust 14, 2007.  The review of the base of the program of the finance of the f	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FREGULATORY OR LSC IDENTIFYING INFORMAT COntinued From page 4  2006 through July 2007 c) Weekend overnight shift: None between since September 30, 2006 and March 4, 2  3508.7 ADMINISTRATIVE SUPPORT  Each GHMRP shall maintain records of reference of the statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to maintain complete account of funds disbursed for Residents #1, #2, and the findings include:  Interview with the program manager on August 16, 2007 at 11:43 AM revealed the group has a manager maintained the receipts of the Residents' expenditures and submitted there administrative office for review and filing he residents financial records. Further intertifith the program manager revealed the group me manager had not been on duty since one manager on August 16, 2007 beginning the financial records revealed no receip re available financial records revealed no receip re	PROVIDER OR SUPPLIER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 4  2006 through July 2007  c) Weekend overnight shift: None between since September 30, 2006 and March 4, 2007  3508.7 ADMINISTRATIVE SUPPORT  Each GHMRP shall maintain records of residents funds received and disbursed.  This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to maintain complete accounting of funds disbursed for Residents #1, #2, ad #3.  The findings include:  Interview with the program manager on August 6, 2007 at 11:43 AM revealed the group home nanager maintained the receipts of the Residents' expenditures and submitted them to be administrative office for review and filing in the residents financial records. Further interview with the program manager revealed the group ome manager had not been on duty since ugust 14, 2007.  ecord review on August 16, 2007 beginning at 1:52 AM revealed the following information uncerning the finances of the residents:  The review of the bank statements for May 07 revealed on May 14, 2007 Residents #1, and #3, each had a withdrawal of \$250,00 m their accounts. The review of the requests the funds indicated the money was be used clothing and personal items. The review of attached the financial records revealed to attach the following information incerning the financial records revealed to the review of the funds indicated the money was be used clothing and personal items. The review of the failable financial records revealed to the following information in their accounts. The review of the financial records revealed to the following information in their accounts. The review of the review of the financial records revealed to the following information in their funds indicated the money was be used clothing and personal items. The review of the financial records revealed to the financial records revealed to the financial records revealed to the financial records r	PROVIDER OR SUPPLIER  SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL RESULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 4  2006 through July 2007  c) Weekend overnight shift. None between since September 30, 2006 and March 4, 2007  3508.7 ADMINISTRATIVE SUPPORT  Each GHMRP shall maintain records of residents funds received and disbursed.  This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to maintain complete accounting of funds disbursed for Residents #1, #2, ad #3.  The findings include:  Interview with the program manager on August 6, 2007 at 11:43 AM revealed the group home manager maintained the receipts of the Residents financial records. Further interview with the program manager revealed the group ome manager had not been on duty since ugust 14, 2007.  eccord review on August 16, 2007 beginning at 1:52 AM revealed the following information merning the finances of the residents:  The review of the bank statements for May 07 revealed on May 14, 2007 Residents #1, and #3, each had a withdrawal of \$250,00 mtheir accounts. The review of the requests the funds indicated the money was be used clothing and personal items. The review of aliable financial records revealed no receipts re available for the \$250.00 withdrawals.	OP CORRECTION  OPG164  PROVIDER OR SUPPLIER  STREET ADDRESS. CITY. STATE. ZIP CODE 617 DAHLIA STREET, NW WASHINGTON, DC 20012  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED by FULL REGULATORY OR LSO IDENTIFYING INFORMATION)  CONTINUED FROM THE PROPERT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSO IDENTIFYING INFORMATION)  CONTINUED FROM THE PROPERT OF DEFICIENCY  CONTINUED FROM THE PROPERT OF TH	OPPROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  617 DANIJLA STREET, MW WASHINGTON, DC 20012  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEPICIENCY MUST BE PRECEDED BY FULL RESULATIONY OR LSC DENTIFYING INFORMATION)  CONDITUDE FROM DAY 2007  CONDITION DAY 2007

DCNJ11

HRA

Ø 053

STATEME! AND PLAN	nt of deficiencies of correction	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU	ERVCLIA IMBER:	A. BUILI		(X3) DATE ( COMPL	
	<u></u>	09G164		B. WINC	<u> </u>	OB!	17 <u>/</u> 2007
NAMEOF	PROVIDER OR SUPPLIER				Y, STATE, ZIP CODE		1112001
NCC	·		617 DAHLI WASHINGT	A STREE	ET, NW 20012		
(X4) ID PREFIX TAG	i (Each Deficiency	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	EID I	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
1 189	Continued From pa	ge 5		I 189			<del></del>
	was needed to dete submitted to the fina b) The review of Refrom September 200 the bank statements \$100.00 less than the Further review of the revealed the discrep by the facility in Sept December 2006 bank is a \$100.00 different ledger. We are still whenk on this issue." It is there was no evidence the discrepancy between the discrepancy between the submitted to the discrepancy of Refront Refro	rmine if the receipts ancial office. esident #1's bank state 56 through July 2007 is reflected a balance the facility's ledger bale facility's monthly led ancy was initially distember 2006. A note the statement indicate ce in the bank and be waiting to follow-up was the time of the surce a thorough investing to determine the original process.	tements revealed of ances dgers covered on the d "There ook vith the vey, gation				
1 202 3:	dedger balances  c) Interview with the August 16, 2007 at 1 desidents went on a state during July 2007 bank statement 530.00 on July 23, 2 and #3. Interview with evealed the home made accipts and they were uring the survey.  509.2 PERSONNEL ach staff person shall escription, which details ponsibilities and durintrol.	program manager of 1:55 AM revealed the summer vacation in a 7. The review of the s revealed a withdraw 007 for Residents #1 the program manager maintained the not available for revealed a written job ails each of his or he	n e e e e e e e e e e e e e e e e e e e	02			
Ba	nis Statute is not me ased on interview and a Administration	t as evidenced by: d record review, the					

09/06/2007 07:30 FAX 2024429430

HRA

**2**054

PRINTED: 09/06/2007 FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A BUILDING 8. WING 09G164 08/17/2007 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CC-DE 617 DAHLIA STREET, NW NCC WASHINGTON, DC 20012 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (X5) COMPLETE DATE PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) 1202 Continued From page 6 1202 1202GHMRP failed to ensure that written job descriptions for the direct care staff were All staff will review and sign a written job description. available for review 10/1/07 The finding includes: Interview and record review with the Quality Assurance Coordinator on August 17, 2007 revealed the job descriptions were not available for \$1, \$2, \$3, \$4, \$5 and \$6. 1 226 3510.5(c) STAFF TRAINING 1226 1226 All staff will be trained in CPR/First Aid This Statute is not met as evidenced by: training. 10/31/07 Based on interview and record review, the GHMRP failed to ensure that current training on cardiopulmonary resuscitation (CPR) was maintained for each employee. The finding includes: The review of training record provided to the surveyor for review on August 16 and August 17, 2007 revealed that two of the six employees working with the residents lacked evidence of a current CPR certification. The identified staff were Staff #'s S2 and S5. Program Manager acknowledged during interview that the CPR certification for the identified staff had either expired or not been completed for the two staff. 1291 3514.2 RESIDENT RECORDS 1294 Each record shall be kept current, dated, and signed by each individual who makes an entry. Health Regulation Administration

DCNJ11

HRA

**47**1055

PRINTED: 09/06/2007 FORM APPROVED

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING B, WING 09G164 08/17/2007 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CCDE 617 DAHLIA STREET, NW NCC WASHINGTON, DC 20012 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PRIVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) COMPLETE TAG TAG DEFICIENCY) 1291 Continued From page 7 1291 This Statute is not met as evidenced by: An access log will be added to all staff Based on interview and record review, the consumer record for signature by staff 10/1/07 GHMRP failed to ensure that the record of each accessing the record. resident was kept current with date and signature of all persons making an entry in the records. (Residents #1, #2 and #3) The findings include: [See Federal Deficiency Report - Citation W114] 3520.3 PROFESSION SERVICES: GENERAL 1401 1401 1 401 **PROVISIONS** Cross-reference W322, W331, and W212 Professional services shall include both diagnosis and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident. This Statute is not met as evidenced by: Based on observation, interview and record ventication, the GHMRP failed to ensure professional services were provided timely for two of three residents in the survey. (Residents #1 and #3) The findings include: The GHMRP failed to ensure health services were provided in accordance with the needs of Residents #1 and #3. [See Federal Deficiency Report - Citations W322, W331 and W212] 1 422 3521.3 HABILITATION AND TRAINING 1422 Each GHMRP shall provide habilitation, training and assistance to residents in accordance with Health Regulation Administration

09/06/2007 07:31 FAX 2024429430

HRA

Ø 056

STATEMEN AND PLAN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU	RICLIA MBER:	A. BUILD		(X3) DATE COMP	SURVEY LETED
		09G164		B. WING		08/	17/2007
NAME OF F	PROVIDER OR SUPPLIER				STATE, ZIP CCIDE		-112001
NCC			617 DAHLI Washingt	A STREE	T, NW 20012		
(X4) ID PREFIX TAG	REGULATORY OR L	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY LSC IDENTIFYING INFORMA	=rm 1	ID PREFIX TAG	PRIVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	711117 65	(X5) COMPLETE DATE
1422	Continued From pa	ige 8		1 422	1 422		<del> </del>
	the resident 's Indi	vidual Habilitation Pla	n.		Cross-reference W227, W249, W252		Ì
1	Based on observati review, the GHMRF #1, #2, and #3 were	met as evidenced by: on, interview and reco failed to ensure Res provided habilitation, their Individual Habili	ord idents				
.  ,	[See Federal Defic W249 and W252]	iency Report - Citatio	n W227,			•	
1 500 :	3523.1 RESIDENT'S	RIGHTS	1	500	1500		
i c	Each GHMRP residence director shall ensuthat the rights of residents are observed an protected in accordance with D.C. Law 2-13 chapter, and other applicable District and fellaws.		nd (37 this		<ul> <li>(1) Cross-reference W140</li> <li>(2) Cross-reference W149, W154, W1</li> <li>(3) Cross-reference W227, W249, W2</li> <li>(4) Cross-reference W322, W331, W3W212</li> </ul>	52	
re	This Statute is not maked on observation eview, the GHMRP for the cities of each classifications of each classifications of each classifications.	let as evidenced by: n, interview and recon alled to ensure the lients rights.	d				
TI	he finding includes:						
ac	esidents #1, #2, and	al funds. ISee Federa					
Po Re	licies and procedure	develop and impleme es on health and safel leral Deficiency Repo Land W156]	to for				
Cite	The facility failed to ents #1, #2, and #3	ensure the rights of to habilitation and trai	ning.		,		

09/06/2007 07:31 FAX 2024429430

HRA

Ø 058

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING	PLE CONSTRUCTION	(X3) DATE S COMPL		
	09G164		·	B. WING		08/1	08/17/2007	
NAME OF P	ROVIDER OR SUPPLIER		617 DAHI	DRESS, CITY, S LIA STREET, STON, DC 20			,	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROMIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE	
R 000	INITIAL COMMENTS		R 000					
R 125	A recertification/licer from August 15, 200 A random sampling selected from a resifemales with mental disabilities. The find based on observation of resident and adminished the reports,  4701.5 BACKGROUThe criminal backgrociminal history of the contract worker for the c	of through August 1: of three residents we dential population of retardation and other lings of the survey was, interviews and the inistrative records in the condition of the c	7, 2007. as six er ere ne review cluding  REMENT close the	. <b>C</b>	₹ 125 Priminal background checks taff.	will be done on all	10/31/07	
i	contract worker for the firm of the firm of the firm of the second within the second of the firm of th	hin which the prospe t worker has worked ven (7) years prior to	ective or the			İ		
fa fa ti w s	Based on the review falled to ensure crimi he previous seven (7 where staff had work seven (7) years prior staff.	of records, the GHM nal background che ?) years, in all jurisdi ed or resided within	IRP cks for ctions the					
T	he finding includes:							
3, ev pi st	Review of the review  , 2007 at 9:20 AM revidence criminal bac revious seven years taff had worked or re riminal background o	evealed the GHMRP ekground checks for in all jurisdiction whe esided. The review of thecks provided review.	failed to the ere two					
					•			
th Regulatio	on Administration		•	· · · · ·	/ TITLE	. //	X6) DATE	
PRATORY DI	REGION SOK PROVIDER	SUPPLIER REPRESENTA	TIVE'S SIGNA	THIPE	France Ols	<i>"</i>	1/1/	